Genitourinary Medicine, while 17.3% specified an inadequate course. Dosage or duration could not be ascertained in 12.7% of responses. This suggests substantial improvement in the past few years,[4] although our study probably over-represents GPs already testing for chlamydia and may exaggerate the extent of good practice.

Our study suggests that GPs already willingly take on an important role in diagnosing and managing genital chlamydia infection. They agree overwhelmingly that partner notification is the main difficulty in managing these patients. However, there is little evidence of follow up strategies designed to minimise re-infection risk, as in previous studies.[5 6] and the majority of GPs consider that partner notification is not their role. The latter view probably explains why the majority manage partner notification by simply telling the patient to deal with it, without support or follow up.

If testing in primary care continues to increase without adequate support for partner notification, much of the resource used in testing women will be wasted. The announcement of pilot sites for chlamydia testing in primary care is to be welcomed.[3] However, support for GPs in partner notification should not wait for the roll out of a national programme, since many patients diagnosed in primary care are already at risk of re-infection and onward transmission.

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J A Cassell, M G Brook
Department of Sexually Transmitted Diseases, Royal Free and University College Medical School, Mortimer Market Centre, Off Capper Street, London WC1E 6AU, UK

R Slack, N James, A Hayward
Division of Public Health Sciences, University of Nottingham Medical School

A M Johnson
Centre for Infectious Disease Epidemiology, Department of Primary Care and Population Sciences and Department of Sexually Transmitted Diseases, University College London, London, UK

Correspondence to: Dr Jackie Cassell, Department of Sexually Transmitted Diseases, Royal Free and University College Medical School, Mortimer Market Centre, Off Capper Street, London WC1E 6AU, UK; jackiec@quadrivium.demon.co.uk

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Circumcision in genital warts—let us not forget!

Patients with genital warts present to the healthcare professional with two major problems of persistence and recurrence. These problems are attributable to the persistence of human papillomavirus in the keratinocytes, defective immune response in individuals with persistence and recurrence of warts, and the lack of specific antiviral therapy. Various treatments tried in the management of genital warts are topical podophyllin, podophyllotoxin, cryotherapy, electrosurgery, chemical cautery, carbon dioxide laser, 5-fluorouracil cream, topical imiquimod cream, and intralesional interferon.[1–3] We wish to highlight the role of circumcision in extensive genital warts involving prepuce, which were refractory to the conventional treatment.

A 50 year old patient presented to us with genital warts for duration of 4 years. On examination, lesions were in the form of sessile, filliform, and papular keratotic verrucous lesions present involving both outer and undersurface of almost whole of the prepuce (fig 1). These lesions were treated by us and in the past by various doctors with topical podophyllin, trichloroacetic acid cautery, electrosurgery, etc, for periods ranging from weeks to months with only minimal response, with the lesions coming back. The patient had some difficulty in retraction of the prepuce and was psychologically disturbed. The patient otherwise was healthy with no evidence of any other disease. Considering the extensive insolvent of prepuce and refractory nature to various treatments, circumcision was performed. Histopathological examination of the excised tissue showed changes consistent with warts without any cellular atypia. Surgical wound healed well in a week with no complications.

Extensive genital warts with evidence of keratinisation are often refractory to podophyllin, podophyllotoxin, and cryotherapy, etc, and are best dealt with surgically or by topical 5-fluorouracil cream. Scissor excision has been mentioned in the treatment of sessile lesions over the shaft of penis, labia majora, and perianal warts.[3] However, circumcision for extensive prepucial warts finds no place in the list of treatments for genital warts in men. In addition to the psychological morbidities, larger and more numerous warts can cause discomfort, and particularly involving prepuce can cause phimosis, secondary infection, and marital disharmony and considerable anxiety in the sexual partner. Globally, approximately 25% of the men are circumcised for religious, cultural, medical, or parental choice reasons. However, controversies surround its benefits and protective effects against STDs.[4] For genital warts, one study has reported a significant association with the lack of circumcision.[5]

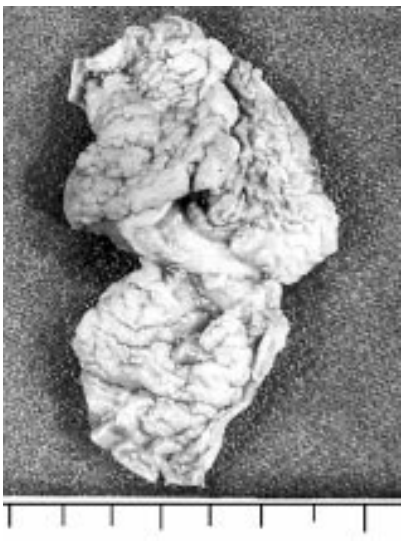

Figure 1 Circumcised prepuce studded with extensive warts.

Substantive evidence supports the premise that circumcision protects males from HIV infection, penile carcinoma, urinary tract infections, and ulcerative STDs.[4] Although it may be debatable to recommend circumcision to reduce the risk of acquiring any one of the other STDs/HIV infection in isolation, taken together however the psychological and sexual discomforts for the patients and their sexual partners with recurrent/persistent extensive prepucial warts, circumcision should be tried.

S Dogra, B Kumar
Department of Dermatology, Venereology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh, India

Correspondence to: Professor Bhushan Kumar, Department of Dermatology Venereology and Leprology, Postgraduate Institute of Medical Education and Research, Chandigarh-160 012, India; kumarbhushan@hotmail.com

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Treatment of *Candida glabrata* using topical amphotericin B and flucytosine

We read with interest the article by White and colleagues on the treatment of *Candida glabrata* using topical amphotericin B and flucytosine because this infection can prove difficult to treat.[1] We have since used this treatment on a 28 year old woman with a 10 year history of recurrent candida.

The woman first attended our department complaining of a recurrent itchy white discharge. She had received numerous courses of antifungals including topical clotrimazole, oral itraconazole, and fluconazole with no relief. Vaginal swabs were positive for *C glabrata* and she was treated with nystatin pessaries 200 000 units at night for 14 nights. Culture was still positive for *C glabrata* at follow up 4 weeks later so she was advised to continue with nystatin pessaries for a further 4 weeks. On review she felt her symptoms were slightly better but she found the pessaries were not dissolving so she was switched to nystatin cream 200 000 units by